OLR Bill Analysis

SB 1240

Emergency Certification

AN ACT CONCERNING THE BUREAU OF REHABILITATIVE SERVICES AND IMPLEMENTATION OF PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND PUBLIC HEALTH.

SUMMARY:

This bill transfers all of the powers, functions, and duties of the (1) Board of Education and Services for the Blind (BESB) and (2) Commission on the Deaf and Hearing Impaired (CDHI) to a new Bureau of Rehabilitative Services (BRS), which is within the Department of Social Services (DSS) for administrative purposes only.

The bill transfers all of the rehabilitation service functions from DSS' current Bureau of Rehabilitation Services to the new BRS. This includes rehabilitation services and disability determinations for people with disabilities who apply for federal Social Security disability benefits.

The bill moves the Department of Motor Vehicles' (DMV) driver training program for individuals with disabilities into BRS. And it transfers the employee rehabilitation program of the Worker's Compensation Commission to BRS.

The bill requires the BRS director to report to the Human Services and Appropriations committees on (1) the merger's status and (2) the vocational rehabilitation services program.

The bill also makes numerous changes to the statutes governing the programs and services of the Department of Social Services (DSS).

The bill makes numerous technical and conforming changes.

§§ 1, 31 — CREATION OF BUREAU

The bill creates a BRS within DSS for administrative purposes only. The bureau is responsible for providing (1) services to blind and visually impaired and deaf and hearing impaired individuals and (2) rehabilitation services.

The bureau is headed by a director, whom the governor appoints in accordance with the law governing appointments of agency heads. The director has the powers and duties of an agency head. The bill requires the director to appoint people he or she deems necessary to administer the bill's provisions. It directs the administrative services commissioner to fix these individuals' compensation.

The bill permits the director to create administration sections within the bureau, including a disability determinations section for which 100% federal funds can be accepted to operate the section in conformance with state and federal regulation. (Currently, DSS' Bureau of Rehabilitation Services has a Disability Determination section that handles Social Security disability determinations for the federal government.)

EFFECTIVE DATE: July 1, 2011

§§ 2-4 — TRANSFER OF CDHI, BESB, AND BUREAU OF REHABILITATION SERVICES FUNCTIONS TO NEW BUREAU

The bill transfers all functions, powers, and duties of CDHI and BESB to the new BRS, and makes BRS a successor administrative agency to the commissions with respect to these functions, powers, and duties. Currently, CDHI and BESB are within DSS for administrative purposes only. BESB is currently the state's lead agency for services for blind residents and offers educational services to children and adults, rehabilitation services, and a program for blind entrepreneurs, among other things. CDHI's main function is to provide interpreters to deaf and hearing impaired citizens in a variety of settings. It also equips these individuals with telecommunication devices.

The bill also transfers all functions, powers, and duties of DSS's

Bureau of Rehabilitation Services to the new BRS.

EFFECTIVE DATE: July 1, 2011

§ 7 — BESB-SPECIFIC CHANGES

The bill changes the role of the BESB oversight board from the central policy making authority for services provided to the state's blind and visually impaired to an advisor to BRS in fulfilling its responsibilities in providing services to blind and visually impaired residents. The bill specifies that BESB board chairman can call a meeting at the request of two or more members instead of exactly two members.

The bill also eliminates the board's function of monitoring the activities of the agency in carrying out its mission to provide educational and rehabilitative services to all blind and visually impaired state residents. And it eliminates a requirement that the board report annually to the governor, OPM, and the legislature on BESB's compliance with benchmarks.

EFFECTIVE DATE: July 1, 2011

§ 33, 35 — CDHI — ROLE OF COMMISSION

As it does with the BESB board, the bill continues CDHI in an advisory role to BRS. But it eliminates its role as a statewide coordinating agency and implementer of state policies affecting the deaf and hearing impaired. (It is unclear to what extent, if any, the commission and not the agency has these roles currently.)

The bill also eliminates the position of the CDHI executive director.

EFFECTIVE DATE: July 1, 2011

§ 38 — DOMESTIC TELEPHONE COMPANY ASSESSMENT

Under current law each domestic telephone company serving at least 100,000 customers had to pay $20,000 into a Special Telecommunications Equipment Fund by July 1, 1992. These funds helped CDHI provide telecommunications equipment for its clients.

The bill eliminates this deadline, thus the telephone companies are once again subject to the assessment. The bill does not specify how frequently the assessment is paid.

EFFECTIVE DATE: July 1, 2011

§ 45 — HANDICAPPED PLACARD CERTIFICATION

By law, people with disabilities seeking or renewing a handicapped placard must present certain certifications to the DMV commissioner verifying they are eligible for one. Under current law, persons who are blind and eligible for these placards require certification of legal blindness from an ophthalmologist, optometrist, or the Board of Education and Services for the Blind. The bill replaces the Board of Education and Services for the Blind with the Bureau of Rehabilitative Services. It also makes technical changes.

EFFECTIVE DATE: July 1, 2011

§ 46 — HANDICAPPED DRIVER TRAINING PROGRAM

The bill moves, from DMV to BRS, a unit that evaluates and trains handicapped people in motor vehicle operation. It changes the name of the program from the handicapped driver training program to the driver training program for persons with disabilities, and makes conforming changes. Under current law, a handicapped driving consultant responsible for overseeing the program is under the DMV commissioner's direction. The bill renames this person the driver consultant for persons with disabilities, and places him under the BRS director.

EFFECTIVE DATE: July 1, 2011

§ 47 — DUTIES OF WORKERS' COMPENSATION CHAIRMEN MOVED UNDER BRS DIRECTOR

The bill makes a number of conforming and technical changes necessary to transfer the employee rehabilitation program of the Workers Compensation Commission (WCC) to the new BRS. The

changes mean WCC will no longer provide employee rehabilitation programs; BRS will take over that function.

Under current law, the WCC chairman must establish rehabilitation programs for workers whose injuries are compensable under state workers compensation law. In order to carry out this program the chairman is authorized to:

1. establish fees,

2. enter into agreements with state and federal agencies, and

3. develop matching programs or activities to secure federal grants and pledge or use funds from the Workers' Compensation Administration Fund.

The bill replaces the WCC chairman with the BRS director and transfer this authority to the director.

EFFECTIVE DATE: July 1, 2011

§ 51 — JANITORIAL WORK PILOT PROGRAM

By law, the DAS commissioner runs a seven-year pilot program to create and expand janitorial work job opportunities for individuals with a disability or a "disadvantage," as defined in law. Currently, the commissioner can consult with the commissioner of social services and the labor commissioner. The bill also allows him to consult with the BRS director.

EFFECTIVE DATE: July 1, 2011

§ 53 — EXEMPTING CERTAIN BRS EMPLOYEES FROM CLASSIFIED SERVICE

Under current law, professional employees of DSS' Bureau of Rehabilitation Services are exempt from the classified service. The bill instead exempts professional employees in the education professional bargaining unit of BRS from the classified service.

EFFECTIVE DATE: July 1, 2011

§ 58 — VOCATIONAL REHABILITATION SERVICES — EMPLOYMENT PLAN

Under current law, vocational rehabilitation services for individuals with disabilities are provided through an individual written rehabilitation program. Under the bill, the services are provided through an individual plan for employment (in conformance with current federal disability law). These plans help individuals reach their work goals.

EFFECTIVE DATE: July 1, 2011

§ 66 — REPORTING TO COMMITTEES OF COGNIZANCE

Under current law, DSS must report annually to the Human Services and Appropriations committees on:

1. DSS' plans to reduce BRS counselor caseloads to the regional average,

2. BRS client information, including age and race, and the nature of their disabilities;

3. DSS' efforts to insure that the bureau is serving as many minorities with disabilities as there are in the state as a whole; and

4. the number, nature, and resolution of complaints the bureau receives.

DSS must also provide the committee with copies of federal audits of BRS.

The bill eliminates the requirement that the committees receive this specific data and instead requires the new BRS, starting July 1, 2011 and each year after that, to provide the committees with the data that it provides to the federal government related to evaluation standards and performance indicators for the vocational rehabilitation services

program.

EFFECTIVE DATE: July 1, 2011

§ 68 — REPORT TO LEGISLATURE

By January 2, 2012, the bill requires the director of BRS to submit a report to the Appropriations and Human Services committees concerning:

1. the status of the merger of BESB, CHDI, and DSS' Bureau of Rehabilitation Services, and the DMV and WCC functions integrated into the new agency;

2. the new bureau's organizational structure;

3. the bureau's places of operation; and

4. any recommendations for further legislative action concerning the merger, including recommendations to increase the efficiency of the new agency and achieve cost savings.

EFFECTIVE DATE: July 1, 2011

§ 69 — ADMINISTRATIVE FUNCTIONS OF OLD AND NEW AGENCY

The bill requires that the personnel, payroll, administrative action, and business office functions of BESB and CDHI not be merged and consolidated into DAS, as was required by 2005 legislation, and instead has BRS assume these functions. But it permits the BRS director to extend the transfers' effective date for six months, up to June 30, 2012, if he or she submits written notice to the Appropriations and Human Services chairs.

EFFECTIVE DATE: Upon passage

§ 70-72 — RECOVERIES OF PUBLIC ASSISTANCE AND OTHER STATE AID

Public Assistance Recipients

By law, the state has a claim against any kind of property or interest in any property acquired by a public assistance recipient. One way the state recovers is by placing liens on the property. The state also has a claim against the parents of children who receive certain aid, but under current law, the state can only place a lien against property of the parent of an Aid to Dependent Children (former name for Aid to Families with Dependent Children (AFDC) program). The bill extends this authority to parents of individuals (presumably children) who receive Temporary Family Assistance (the current family cash welfare program that replaced AFDC) and State-Administered General Assistance (SAGA).

The state can also make a claim when a public assistance recipient inherits money and is entitled to 50% of the assets of the estate or the amount of the assistance, whichever is less. This amount is assignable to the state for payment. The bill applies this provision to parents of these assistance recipients. It requires the probate court to accept these new assignments. The bill also makes conforming, technical changes.

Patients in State Humane Institutions

By law, a patient who is receiving or has received care or support in a state humane institution (e.g., Department of Mental Health and Addiction Services (DMHAS) facility) or his or her estate are liable to reimburse the state for any unpaid portion of the per capita cost the institution charges to the same extent as public assistance recipients with respect to property and estate recoveries, but not lawsuits and inheritances. The bill applies the lawsuit and inheritance recovery provisions to these individuals.

EFFECTIVE DATE: July 1, 2011

§ 73 — NURSING HOME RATES

The bill freezes for the next two fiscal years the Medicaid reimbursement to nursing homes. By law and regulation, homes should be getting higher rates due to rate re-basing and inflationary adjustments. Under the bill, facilities that would have been issued

lower rates in either year due to their interim rate status receive the lower rate.

Currently, facilities that undergo material changes in circumstances related to fair rent (e.g., building an addition) have an additional payment built into their rate. In FYs 10 and 11, these additional payments can be made only if the homes have an approved certificate of need (presumably for these material changes). The bill extends this limitation for the next two fiscal years.

Despite this general prohibition on rate increases, the bill permits the DSS commissioner, within available appropriations, to increase rates (presumably to reflect increases that result from the budget's increase in the nursing home provider tax).

EFFECTIVE DATE: July 1, 2011

§§ 74 & 75 — RATES FOR INTERMEDIATE CARE FACILITY AND RESIDENTIAL CARE HOMES

Under the bill, the Medicaid rates of intermediate care facilities for people with mental retardation (ICF/MR) and residential care homes are frozen at the FY 11 rate for FYs 12 and 13. However, during those fiscal years, (1) an ICF/MR assigned a lower rate due to interim rate status or by agreement with DSS gets the lower rate and (2) the DSS commissioner may pay fair rent increases to any facility that has undergone a material change and has an approved certificate of need. Although the bill freezes the rates, it authorizes the DSS commissioner to increase rates ICF/MR within available appropriations. It also authorizes the DSS commissioner to increase residential care rates for reasonable costs associated with initiating a program to certify unlicensed health care personnel to administer non-injectible medication in FYs 12 or 13.

EFFECTIVE DATE: July 1, 2011

§ 76 — REIMBURSEMENTS FOR OUTPATIENT PRESCRIPTION DRUGS DISPENSED TO DSS MEDICAL ASSISTANCE RECIPIENTS

The bill reduces the reimbursement DSS pays pharmacists for dispensing most drugs to DSS medical assistance recipients. Currently, DSS pays the average wholesale price (AWP) of the drug, minus 14%, plus a $2.90 dispensing fee. Under the bill, the reimbursement falls to AWP minus 16% plus a $2 dispensing fee.

EFFECTIVE DATE: July 1, 2011

§ 77 — TEMPORARY FAMILY ASSISTANCE AND STATE ADMINISTERED GENERAL ASSISTANCE PAYMENTS

The bill freezes Temporary Family Assistance (TFA) and State Administered General Assistance (SAGA) payment standards at the FY 10 rate for the next two fiscal years. It retains the existing formula for calculating increases for future years.

EFFECTIVE DATE: July 1, 2011

§ 78 — FREEZE IN STATE SUPPLEMENT BENEFITS

The bill freezes benefits in the State Supplement to Supplemental Security Income program for the next two fiscal years.

EFFECTIVE DATE: July 1, 2011

§§ 78 & 79 — DECREASE IN PERSONAL NEEDS ALLOWANCE

Currently, residents of long-term care facilities who receive Medicaid generally must spend all of their monthly income (e.g., Social Security) towards their care costs, but may keep a small portion called a personal needs allowance to pay for incidentals. The amount of the allowance is increased each year based on any increases in Social Security benefits (COLA), although the statute does not include the updated amounts. Currently, the allowance is $69 per month. The bill reduces the allowance to $60 and eliminates the Social Security COLA indexing. The covered facilities include nursing homes, chronic disease hospitals, ICF-MRs, and state humane institutions.

EFFECTIVE DATE: July 1, 2011

§ 80 — CHARTER OAK HEALTH PLAN

The bill excludes from coverage in Connecticut's health insurance plan for the uninsured (Charter Oak Health Plan) anyone who is eligible for the high risk pool (the Pre-Existing Condition Insurance Program) established under the federal Patient Protection and Affordable Care Act. The bill eliminates a prohibition against excluding preexisting conditions from coverage under the Charter Oak plan.

The bill reduces the number of low-income people eligible for premium assistance by closing the program to all those not enrolled on May 31, 2010. It also reduces the amount of the DSS premium subsidy by lowering the range of its sliding scale, which bases the amounts on the extent to which a person's income is above the federal poverty level. Currently, the range is between $50 and $175; under the bill, it is between $35 and $115. As under existing law, those with incomes above 300% of the federal poverty level do not qualify for premium assistance.

EFFECTIVE DATE: September 1, 2011

§ 81 — MEDICAID NON-EMERGENCY DENTAL SERVICES

The bill directs the DSS commissioner to modify the availability of nonemergency adult services (age 21 and older) to people who do not appear to have a dental disease that is an aggravating factor in their overall health. Modifications must include providing one periodic exam, one dental cleaning, and one set of bitewing x-rays per year.

Policies, Procedures, and Regulations

The bill authorizes the DSS commissioner to implement policies and procedures to administer the program while in the process of adopting them in regulation form, so long as he publishes a notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementing the policies and procedures. The policies and procedures are valid for three years following the publication date

unless the legislature calls for something otherwise.

Notwithstanding a requirement that proposed regulations be submitted within 180 days after adoption, the bill requires policies and procedures concerning this program to be submitted in proposed regulation form to the legislative Regulation Review Committee no later than three years after the *Law Journal* notice is published. If the commissioner is unable to submit the proposed regulations by that deadline, he must submit a written notice to the Appropriations, Human Services, and Regulation Review Committees at least 35 days before the proposed regulations are due.

Under the bill, the notice must indicate (1) why DSS cannot meet the deadline and (2) the date by which the department will submit its proposed regulations. The Regulation Review Committee can require the commissioner to appear before the committee at a time it sets to further explain his reasons and to respond to the committee's policy questions. The committee may ask the Human Services Committee to review (1) the DSS policies, (2) its reasons for not submitting proposed regulations on time, and (3) the date on which it intends to submit them. The Human Services Committee may review this information, schedule a hearing about it, and make a recommendation to the Regulation Review Committee.

EFFECTIVE DATE: July 1, 2011

§ 82 — CAPITAL IMPROVEMENTS TO FACILITIES FOR THE SEVERELY HANDICAPPED

For FY 12 and 13, the bill freezes rates at the FY 11 level for licensed private residential facilities and similar facilities operated by regional educational service centers that provide vocational or functional services for severely handicapped individuals. Any facility that would have gotten a lower rate due to interim rate status or agreement with DSS gets the lower rate.

The rate may be higher if the facility makes a capital improvement in FYs 11 or 12 required by the DDS commissioner for resident health

and safety.

EFFECTIVE DATE: July 1, 2011

§ 83 — DSS REPORT ON SUBMITTING REGULATIONS

The bill requires the DSS commissioner, by July 1, 2012, to report to the Appropriations and Human Services committees concerning the department's regulation process and the status of policies and procedures implemented for which proposed regulations have not been submitted to the Regulation Review Committee. He must report at least on the status of regulations with respect to (1) adult day care services, (2) medical homes, and (3) low income adults (LIA).

The report must include:

1. the duties of staff assigned to work on the proposed regulations;
2. the need for additional staff and the duties they would perform;
3. a timetable for training new staff to assist in the regulation process;
4. a description of the system supports used and needed for efficiency and delivery of proposed regulations;
5. a description of departmental policies and procedures that have not been submitted to the Regulation Review Committee, including the dates on which the policies and procedures were implemented; and
6. a timetable for submitting them to the committee.

EFFECTIVE DATE: Upon passage

§ 84 — TRANSPORTATION

For emergency medical transportation for people eligible for both Medicaid and Medicare, the bill limits reimbursement for Medicare coinsurance and deductibles to ensure that the combined Medicaid

and Medicare provider payment does not exceed the maximum allowable under Medicaid plus an additional percentage, which the DSS commissioner must develop.

EFFECTIVE DATE: July 1, 2011

§ 85 — FOREIGN LANGUAGE INTERPRETERS AND PODIATRY COVERAGE

Interpreters

PA 09-5, September Special Session (SSS) required DSS to amend the Medicaid state plan by February 1, 2011, to include foreign language interpreter services as a "covered service" to any beneficiary with limited English proficiency. DSS also was supposed to establish billing codes for interpreter services provided under the Medicaid and HUSKY B programs. DSS has not amended the plan or developed these codes. The bill continues this directive, eliminates its applicability to HUSKY B, and delays its implementation until July 1, 2013.

PA 09-5, SSS directed each managed care organization (MCO) that contracted with DSS to provide interpreter services to HUSKY A recipients to submit semiannual reports to DSS, which the department submits to the Medicaid Care Management Oversight Council. The bill instead requires DSS to report directly to the newly named council (see below), effective July 1, 2013.

Federal Medicaid law allows states to receive federal matching funds for limited English proficiency interpreters, either by designating them as (1) a covered state plan service or (2) an administrative cost.

Podiatry

The bill restores Medicaid coverage for podiatry services as a state plan service. It directs the DSS commissioner to amend the Medicaid state plan by October 1, 2011 to effect the change. Since 2003, DSS has not paid for podiatry services performed by independent practitioners.

It has paid for them when provided by physicians (orthopedists) and clinics.

EFFECTIVE DATE: July 1, 2011

§ 86 — CONNECTICUT HOME CARE PROGRAM FOR ELDERS — COST SHARING IN STATE FUNDED PORTION OF PROGRAM

The Connecticut Home Care Program for Elders provides home- and community-based services to frail elders as an alternative to nursing home care. The program has state- and Medicaid-funded components. The bill increases cost sharing for the state-funded portion of the program from 6% to 7% of service costs. For people with higher incomes, this charge is in addition to any income DSS applies toward the cost of their care.

EFFECTIVE DATE: July 1, 2011

§ 87 — EMERGENCY MEDICAL SERVICES

The budget bill (PA 11-6) requires $ 1.45 million to transferred from the Tobacco and Health Trust Fund for three items, including emergency medical services. Currently, $500,000 in grants is allocated for grants to regional councils for emergency medical services. This bill allocates the money to regional emergency medical services.

EFFECTIVE DATE: July 1, 2011

§§ 88-90 — CONNPACE FOR PEOPLE INELIGIBLE FOR MEDICARE

ConnPACE traditionally has provided prescription drug assistance to individuals age 65 and older and younger people with disabilities, many of whom are Medicare Part D recipients.

Currently, for people eligible for Medicare, ConnPACE pays any Medicare Part D prescription co-payments over ConnPACE's $16.25 and any Part D plan's premiums and deductibles. It also pays for prescriptions needed during the coverage gap ("donut hole"). The bill eliminates all of this, but it continues to offer drug assistance to people

(primarily younger adults with disabilities) who do not qualify for Medicaid or Medicare.

Most individuals eligible for ConnPACE and Medicare qualify for the Medicare Savings Program (see below), which makes them eligible for the federal Low-Income Subsidy (LIS) program. LIS offers Part D recipients significant premium and co-payment subsidies, and pays for the donut hole (which starts when annual drugs costs reach $2,840 and continues until they reach $6,448).

The bill also eliminates the Medicare Part D Supplemental Needs Fund, which paid for drugs ConnPACE recipients needed that were not in their Part D plan's formulary. DSS stopped making payments from this fund in January 2010.

EFFECTIVE DATE: July 1, 2011

§ 91 — MEDICARE SAVINGS PROGRAM (MSP)

The MSP provides Medicaid-funded help with Medicare cost sharing to lower income individuals who are eligible for Medicare Part A and B. In 2009, eligibility for the program was expanded to enable most ConnPACE recipients to qualify. An individual who qualifies for the MSP is automatically eligible for the Medicare Part D low-income subsidy, which helps with Part D cost sharing, including payments during the coverage gap.

Under current law, DSS is required to increase the income disregards used to determine MSP eligibility in an amount that equalizes the income limit with the ConnPACE program. The bill requires DSS to also equalize any deductions allowed under the MSP.

EFFECTIVE DATE: July 1, 2011

§ 92 — MEDICAID OUTPATIENT FEE SCHEDULE

The bill authorizes the DSS commissioner to establish a uniform fee schedule for Medicaid-covered outpatient hospital services. Currently, its payment formula results in different hospitals being paid at

different rates for the same services.

EFFECTIVE DATE: July 1, 2011

§ 93 — AIDS PROGRAM WAIVER

The bill reduces, from 100 to 50, the number of people eligible to participate in the Medicaid home- and community-based services waiver for people with HIV or AIDS who would otherwise need institutional care. It eliminates a reference to a federal regulation (42 CFR 440.180) that allows the commissioner to decide what services are necessary for a participant's unique needs to avoid institutionalization.

EFFECTIVE DATE: July 1, 2011

§ 94 — EYEGLASS COVERAGE

The bill reduces the frequency with which DSS will pay for eyeglasses from once per year to once every other year. It directs the commissioner to administer eyeglass and contact lens payments as cost effectively as possible.

EFFECTIVE DATE: July 1, 2011

§ 95 — LIMITATION ON SMALL HOUSE NURSING HOME PROJECTS

Existing law requires the DSS commissioner, within available appropriations, to establish a pilot program to support the development of up to 10 licensed small house nursing homes. (These facilities are modeled after private homes and afford residents more privacy, increased support staff, and individualized care.) He can approve one project with up to 280 beds before June 30, 2011.

The bill makes the program permissive and limits its scope to one facility with up to 280 beds. It also increases, from 10 to 14, the maximum occupancy for each unit. In doing so, it repeals provisions in current law allowing nursing homes to develop and relocate beds to their small house nursing homes, thus reducing the number of

institutional nursing facility beds in the state.

EFFECTIVE DATE: July 1, 2011

§ 96 — SECURITY DEPOSIT GUARANTEE PROGRAM

By law and within available appropriations, DSS administers a program that provides landlords a security deposit guarantee when they rent a unit to specified low income tenants, the homeless, or those subject to eviction proceedings. Currently, potential tenants are ineligible if DSS previously paid two damage claims on their behalf within the five-year period prior to their new application. The bill makes tenant-applicants on whose behalf DSS ever paid two claims ineligible for the program.

Currently, tenants have no obligation to contribute to the rent or security deposit under this program. Under the bill, those (1) with incomes greater than 150% of the federal poverty level and (2) for whom DSS has paid a damage claim, must pay 5% of one month's rent towards payment of the security deposit. The DSS commissioner may waive this requirement for cause.

The bill also gives landlords 45 days after the termination of a tenancy to submit a damage claim. DSS will only pay claims that are accompanied by receipts indicating that the repairs have been made. It also will not pay when a tenant moves out because the unit is uninhabitable as determined by a local, state, or federal regulatory agency.

EFFECTIVE DATE: July 1, 2011

§§ 97-101 — CHILD CARE AND SCHOOL READINESS PROGRAMS TRANSFERRED FROM DSS TO STATE DEPARTMENT OF EDUCATION (SDE)

Currently, DSS, in consultation with the State Department of Education (SDE) (1) provides direct subsidies to providers for child care slots and (2) awards grants to school readiness programs for quality enhancements. The bill eliminates DSS' role in these programs

and permits, instead of requires, the SDE commissioner to model its direct provider subsidy on the Care4Kids child care subsidy program, which DSS administers. The bill requires the SDE commissioner, effective July 1, 2011, to pay funds under the quality grant program to providers on a prospective basis.

The bill also makes the SDE commissioner alone responsible for (1) coordinating the development of a range of alternative programs to meet the needs of all children, (2) fostering partnerships between school districts and private organizations, (3) providing information and assistance to parents in selecting school readiness programs, and (4) working to ensure that such programs allow open enrollments.

The bill also makes the education commissioner, instead of the DSS commissioner, responsible for administering the child care facilities loan guarantee program and the child care facilities direct revolving loan program.

EFFECTIVE DATE: July 1, 2011

§§ 102 & 103 — TAX ON HOSPITAL NET REVENUE

Under the budget act (PA 11-6), hospitals are assessed a quarterly tax on net patient revenue. Currently, net patient revenue is defined as the amount of a hospital's gross revenue, including any Medicare payments. Under the bill, this revenue is the amount of accrued payments a hospital earns for providing inpatient and outpatient services.

Under PA 11-6, other than for the Connecticut Children's Medical Center (CCMC) and John Dempsey Hospital, the tax is 4.6% of hospitals' net patient revenue. The bill provides that the amount of the tax is the maximum allowed by federal law. It requires the DSS commissioner to determine the base year on which the tax is assessed. And it allows the commissioner, in consultation with the secretary of the Office of Policy and Management (OPM) and in accordance with federal law, to exempt a hospital from the tax on payments earned from providing outpatient services based on financial hardship.

EFFECTIVE DATE: July 1, 2011, and applicable to calendar quarters starting on or after that date.

§ 104 — ASSET TRANSFERS BY NURSING HOME RESIDENTS

The law prohibits institutionalized individuals (under the bill, defined as residents of nursing homes or similar facilities or receiving home and community-based services under a Medicaid waiver) from transferring or assigning their assets for less than fair market value in order to qualify for Medicaid. Penalties attach when such transactions occur within five years before the nursing home resident applies for Medicaid. The bill sets penalty trigger dates for some of these transactions.

Transfers

Under the bill a resident can be penalized for an asset transfer even if the entire amount is returned when DSS determines that the circumstances surrounding the transaction indicate that the Medicaid recipient or his or her spouse or authorized representative intended from the time the asset was transferred to change the start date of the penalty period or shift nursing facility costs to the Medicaid program. Unless the transferor can prove otherwise by clear and convincing evidence, the entire amount of the returned asset is deemed available from the date of the transfer. If the transferor prevails, the asset is deemed available from the date of its return.

The conveyance and subsequent return of an asset for the purpose of shifting costs to the Medicaid program is deemed to be a trust-like device, and the asset will be considered available for the purposes of determining Medicaid eligibility.

The bill also specifies that a partial return of a transferred asset will not reduce the penalty period.

EFFECTIVE DATE: Upon passage

§ 105 — SCHOOL-BASED CHILD HEALTH PROGRAM

Federal law requires local education agencies (LEAs) to identify all children with disabilities who need special education and related services. The LEAs must provide the related services and, for Medicaid-eligible students, bill DSS for their cost. DSS (1) bills the federal government for 100% of what the LEA spends, (2) keeps one-half of the reimbursement, and (3) passes the other half to the LEA. These services are diagnostic, evaluative, and rehabilitative in nature.

The bill requires DSS to amend its Medicaid state plan for this program to maintain and enhance, to the extent allowed, federal matching funds associated with costs through a service-specific, rather than the current "bundling" of services, billing method. The bill eliminates an obsolete provision regarding the content of the state plan amendment.

The bill requires the DSS commissioner to notify each LEA in writing of any change in policy or billing procedure within 30 days after the change's effective date.

EFFECTIVE DATE: Upon passage

§§ 106 & 107 — COVERAGE FOR SMOKING CESSATION AND CERTAIN OVER-THE-COUNTER DRUGS; BILLING FOR DIABETIC SUPPLIES

By law, the DSS commissioner was to have amended the Medicaid state plan to cover smoking cessation treatment for Medicaid patients when prescribed by a licensed health care professional. This was never done. The bill continues to require DSS to amend the state plan but removes the requirement that treatment be ordered by a health care professional. Thus, the bill allows treatment coverage for all prescription and over-the-counter drugs and counseling.

Under current law, if the initial treatment is not successful, all prescriptive options must be made available to the patient. The bill eliminates this provision.

The bill adds smoking cessation drugs to the list of drugs that are

exempt from the general ban on DSS payments for over-the-counter drugs, but this does not become effective until January 1, 2012.

The bill also requires the DSS commissioner, by August 1, 2011, to notify pharmacists participating in any DSS medical assistance program that they may bill DSS for supplies used in diabetes treatment using the durable medical equipment-medical surgical supply fee schedule. Providers currently receive electronic notifications about the fee schedule. The commissioner must provide a copy of the notice to the Human Services and Appropriations committees.

EFFECTIVE DATE: January 1, 2012, for the general smoking cessation coverage provisions and July 1, 2011, for the diabetic supplies and over-the-counter drug exception provisions.

§ 108 — SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

By law, certain relatives are legally responsible for repaying the state the amount for public assistance benefits the other relative (usually a spouse or minor child) receives. They are required to report to DSS any increases in income or acquisition of property within 10 days of receipt. The bill excludes relatives of Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) recipients from the reporting requirements. SNAP recipients are not required to repay the state for benefits they receive.

EFFECTIVE DATE: Upon passage

§ 109 — HUSKY B COST SHARING

The bill eliminates the law's specific premiums that HUSKY B, Band 2 families must pay for their children's care. By law, DSS can charge premiums for families with incomes greater than 235% of the federal poverty level (FPL, which is $52,522 for a family of four in 2011).

Under current law, families pay $38 per month with a family cap of $60, but the federal government recently determined that these premiums, which were increased in 2010, violated federal law (see

BACKGROUND) and DSS is reimbursing families as a result. (Lower income, Band 1 families only have a co-payment obligation.) The bill allows DSS, in accordance with federal law, to impose premiums, and for the next four fiscal years, annually increase the premiums based on any increase in the consumer price index for medical care services.

The bill also removes a requirement that DSS not impose a premium requirement on families with incomes between 185% and 235% (Band 1) of the FPL.

EFFECTIVE DATE: Upon passage

§ 110 — MEDICAL HOMES

The bill permits the DSS commissioner to establish medical homes as a model for delivering care to recipients of department-administered medical assistance programs. The model is for people eligible for Medicaid or a Medicaid waiver who have one or more of (1) two chronic conditions, (2) one chronic condition with a risk of developing a second, or (3) a serious and persistent mental health or substance abuse condition. Its components include:

1. comprehensive case management;
2. care coordination and health promotion;
3. comprehensive transitional care including appropriate follow up, from inpatient to other settings;
4. patient and family support;
5. referral to community and social support services, if relevant; and
6. use of health information technology to link services.

The commissioner may implement necessary policies and procedures to implement the model homes.

In addition, the bill allows him to implement policies and

procedures to carry out optional provisions of the federal Patient Protection and Affordable Care and Health Care and Education Reconciliation acts (PL 111-148) relating to:

1. family planning services,
2. establishing a temporary high risk pool for individuals with preexisting conditions,
3. establishing an incentive program to prevent chronic diseases,
4. providing health homes to medical assistance beneficiaries with chronic conditions,
5. establishing Medicaid payments to institutions for a mental disease demonstration program,
6. establishing a dual eligible demonstration program,
7. establishing a balancing incentive payment program for home and community-based services,
8. establishing a "Community First" option,
9. establishing a demonstration project to make bundled payments to hospitals, and
10. establishing a demonstration project to allow pediatric medical providers to organize as accountable care organizations.

Policies, Procedures, and Regulations

The bill authorizes the DSS commissioner to implement policies and procedures to administer the program while in the process of adopting them in regulation form, so long as he publishes a notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementing the policies and procedures. The policies and procedures are valid for three years following the publication date unless the legislature calls for something otherwise.

Notwithstanding a statute that requires proposed regulations to be submitted within 180 days after adoption, the bill requires policies and procedures concerning this program to be submitted in proposed regulation form to the legislative Regulation Review Committee no later than three years after the *Law Journal* notice is published. If the commissioner is unable to submit the proposed regulations by that deadline, he must submit a written notice to the Appropriations, Human Services, and Regulation Review Committees at least 35 days before the proposed regulations are due.

Under the bill, the notice must indicate (1) why DSS cannot meet the deadline and (2) the date by which the department will submit its proposed regulations. The Regulation Review Committee can require the commissioner to appear before the committee at a time it sets to further explain his reasons and to respond to the committee's policy questions. The committee may ask the Human Services Committee to review (1) the DSS policies, (2) its reasons for not submitting proposed regulations on time, and (3) the date on which it intends to submit them. The Human Services Committee may review this information, schedule a hearing about it, and make a recommendation to the Regulation Review Committee.

EFFECTIVE DATE: Upon passage

§§ 111, 174-177 — DISPROPORTIONATE SHARE (DSH) PAYMENTS TO HOSPITALS

DSH Payments Based on Actual Costs

The bill modifies DSH payments to conform to federal law. Under current law, DSS, within available appropriations, is permitted to make twice monthly payments to short-term general hospitals that serve a disproportionate share (DSH) of low-income patients and provide uncompensated care. These state payments are eligible for federal matching funds. Currently, the hospitals can receive these "interim payments" based on a prior year's data without recalculating the payments using the year's actual data and redistributing the difference between the two through a "settlement" process, and state

law prohibits settlements.

The federal Medicaid agency is now requiring states, after September 30, 2010, to use the current year's actual data and use a settlement process. If the interim payment exceeds its upper payment limit (UPL), the balance must be recovered from the hospital. But if state law and the state's Medicaid plan specifies that the excess above the UPL can be redistributed to hospitals that have not reached their UPL, no federal funds have to be returned.

Under the bill, starting July 1, 2011, DSS, within available appropriations, can make interim monthly DSH payments. The total amount of these payments individually and in the aggregate must maximize federal Medicaid matching payments, as DSS determines in consultation with OPM. The bill prohibits DSH payments to CCMC or John Dempsey Hospital. DSS determines the DSH payment amount based on information the hospitals submit as required by the federal Affordable Care Act.

Also starting July 1, 2011, interim DSH payments for the next 15 months must be based on 2009 federal fiscal year data and can be adjusted at the DSS commissioner's discretion for accuracy. Effective October 1, 2012, these payments must be based on the most recent federal fiscal year payments made to hospitals individually and in the aggregate and must maximize federal matching Medicaid payments, as DSS determines in consultation with OPM.

For FFY 11 and succeeding fiscal years, final DSH payment amounts must be recalculated and reallocated in accordance with federal law, despite any law to the contrary that would prohibit this.

The bill requires the DSS commissioner to prescribe uniform annual hospital data reporting forms.

Any payments made under these provisions are in addition to inpatient hospital rates. The bill permits the commissioner to withhold a payment to a hospital to offset any money the hospital may owe the state.

Conforming Changes to Existing Law

In accordance with the above provisions, the bill makes a number of changes in existing law. It (1) eliminates obsolete DSH-related provisions currently in DPH's Office of Health Care Access division (OHCA) statutes, (2) makes changes to hospital auditing and filing requirements, and (3) makes conforming and technical changes.

Current law requires OHCA, in consultation with DSS, to review annually each hospital's level of uncompensated care to the indigent. Under the bill, OHCA does not have to consult with DSS.

The bill eliminates a requirement that each hospital get an independent audit of its level of charges, payments, and discharges to government and nongovernment payers and the amount of uncompensated care. But the hospital must continue to file its audited financial statements by February 28 annually. The bill requires that this filing include a verification of the hospital's net revenue for the most recently completed fiscal year in an OHCA-prescribed format. The definition of "net revenue" means total gross revenue less contractual allowance , less the difference between government charges and government payments, less uncompensated care and other allowances, plus DSS uncompensated care program DSH payments. The bill eliminates the DSH payments from the definition.

The bill also requires OHCA to report to the Public Health Committee, by September 1 annually, on its review of hospitals' required annual and twelve-month filings concerning uncompensated care, authorized revenue limits, and other hospital data instead of reporting each June 1 on the results of an uncompensated care audit for the previous fiscal year.

EFFECTIVE DATE : July 1, 2011

§ 112 — BLENDED INPATIENT HOSPITAL RATES

The bill requires DSS, after consulting with the Office of Policy and Management and the Mental Health and Addiction Services and

Public Health commissioners, to submit a plan to the Appropriations and Human Services committees for implementing a cost neutral, acuity-based method for establishing hospital rates. The plan is due January 1, 2012 and must be phased in over time.

Under the bill, the DSS commissioner may establish a blended inpatient hospital case rate. It must include services provided to all Medicaid recipients and may exclude certain diagnoses if the DSS commissioner determines the rates are necessary to ensure that the planned conversion to an administration services organization (ASO) is, in the aggregate, cost neutral to hospitals and ensures patient access.

EFFECTIVE DATE: July 1, 2011

§ 113 — MODIFIED FEE SCHEDULES FOR CHRONIC DISEASE AND STATE-FUNDED HOSPITALS

The bill permits the DSS commissioner to annually modify fee schedules for outpatient services in chronic disease hospitals and hospitals receiving state appropriations. The purpose of the modification is to ensure that the conversion to an ASO is, in the aggregate, cost neutral to hospitals and ensures patient access.

It also repeals an obsolete reporting requirement.

EFFECTIVE DATE: July 1, 2011

§ 114 — FEE SCHEDULES FOR HOME HEALTH CARE AGENCIES

The bill eliminates the DSS commissioner's discretionary authority to annually increase a home health care or homemaker-home health agency's fee schedule for Medicaid services when there is an increase in the cost of services. Instead, he may annually modify the schedule to ensure that the conversion to an ASO is cost-neutral, in the aggregate, to home health care agencies and homemaker-home health agencies and ensure patient access. By law, the commissioner is authorized to contract with ASOs for care coordination, utilization and disease management, customer services, and grievance reviews for medical assistance recipients.

EFFECTIVE DATE: July 1, 2011

§ 115 — MEDICAL SERVICE RATES

By law, DSS may contract with an ASO to provide care coordination, utilization and disease management, customer service, and grievance reviews for medical assistance programs. The bill authorizes the commissioner to establish payment rates for medical services providers if establishing the rates is required to ensure that any contract with an ASO is cost neutral to hospitals in the aggregate and ensures patient access.

EFFECTIVE DATE: July 1, 2011

§ 116 — ALTERNATIVE MEDICAID BENEFIT PACKAGE FOR FOR LOW-INCOME ADULTS

Benefit Package

The bill permits the DSS commissioner to amend the Medicaid state plan to establish an "alternative benefit package" for individuals eligible for Medicaid under the Low-Income Adult (LIA) coverage group and to limit medical services provider rates. The bill allows the package to limit:

1. health care provider office visits;
2. independent therapy services;
3. emergency room services;
4. inpatient and outpatient hospital visits;
5. medical equipment, devices, and supplies;
6. ambulatory surgery center services;
7. pharmacy services;
8. nonemergency medical transportation; and

9. home care agency services.

Effective July 1, 2011, the bill prohibits DSS from paying a medical provider for services provided before April 1, 2010, to a LIA recipient. (Before that date, such individuals would have their services paid for by the SAGA medical assistance program, which LIA replaced.)

Implementation

The bill authorizes the DSS commissioner to implement policies and procedures to administer the program while in the process of adopting them in regulation form, so long as he publishes a notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementing the policies and procedures. The policies and procedures are valid for three years following the publication date unless the legislature calls for something otherwise.

Notwithstanding a statute that requires proposed regulations to be submitted within 180 days, the bill requires policies and procedures concerning this program to be submitted in proposed regulation form to the legislative Regulation Review Committee no later than three years after the *Law Journal* notice is published. If the commissioner is unable to submit the proposed regulations by that deadline, he must submit a written notice to the Appropriations, Human Services, and Regulation Review Committees at least 35 days before the proposed regulations are due.

Under the bill, the notice must indicate (1) why DSS cannot meet the deadline and (2) the date by which the department will submit its proposed regulations. The Regulation Review Committee may require the commissioner to appear before the committee at a time it sets to further explain his reasons and to respond to the committee's policy questions. The committee may ask the Human Services Committee to review (1) the DSS policies, (2) its reasons for not submitting proposed regulations on time, and (3) the date on which it intends to submit them. The Human Services Committee may review this information, schedule a hearing about it, and make a recommendation to the Regulation Review Committee.

EFFECTIVE DATE: July 1, 2011

§ 117 — RESIDENTIAL FACILITY FOR FORMER PRISONERS AND DMHAS CLIENTS

The bill permits the Department of Correction, DSS, and DMHAS commissioners to establish or contract to establish a chronic or convalescent home on state-owned or private property. The facility is for people who:

1. require nursing home-level services and are transitioning from prison into the community or

2. are DMHAS clients.

The facility's development is exempt from the state's certificate of need requirements.

EFFECTIVE DATE: July 1, 2011

§ 118 — LIMITED MEDICAL SERVICES TO LEGAL IMMIGRANTS LIVING IN THE U.S. FOR LESS THAN FIVE YEARS

Until 2009, the state provided medical services to low-income legal immigrants (State Medical Assistance for Noncitizens, SMANC) living in the U.S. for less than five years (after that, federal assistance is available). PA 09-5, SSS eliminated most of this assistance. It continued assistance for those immigrants who were receiving home care services or nursing home care under the SMANC program on September 8, 2009, as long as they met the eligibility criteria. Assistance also continued for individuals receiving nursing home care who applied for SMANC before September 8, 2009, and would otherwise be eligible for it. (The act also continued medical assistance for pregnant women and children until the state was eligible to receive federal funding to cover these two groups, which it subsequently did.)

The law was never implemented because DSS was sued and the Superior Court ruled in favor of the plaintiff immigrants. The state Supreme Court recently overturned that decision (see

BACKGROUND), thus allowing DSS to implement the 2009 law.

Currently, the law allows certain elderly immigrants who are receiving long-term care services to continue to get this care. Under the bill, immigrant elders continue to get coverage if the are receiving (1) home care receive services that are equivalent to those provided under the Medicaid waiver portion of the Connecticut Home Care Program for Elders, rather than simply home care; (2) SMANC-funded nursing home care as of June 30, 2011; or (3) receiving care and applying for SMANC before June 1, 2011.

EFFECTIVE DATE: Upon passage

§ 119 — LIMITED COVERAGE FOR ILLEGAL IMMIGRANTS

Under current law, the DSS commissioner, within available appropriations and after consulting with the commissioner of mental health and addiction services and the OPM secretary, may provide payments to long-term care facilities for the care of certain illegal immigrants. Under the bill, these individuals have to be admitted to such a facility by July 1, 2011.

EFFECTIVE DATE: Upon passage

§§ 120-141 — ELIMINATION OF STATE-ADMINISTERED GENERAL ASSISTANCE (SAGA) MEDICAL ASSISTANCE PROGRAM

PA 10-1, June Special Session created a new Medicaid coverage group for Low-Income Adults (LIA). Anyone eligible for the SAGA medical assistance program was moved into LIA since the eligibility criteria were the same. This bill eliminates the SAGA medical assistance program and most statutory references to it and in some instances, replaces SAGA medical assistance with LIA.

EFFECTIVE DATE: July 1, 2011

§ 142, 178 — ELIMINATION OF MEDICARE PART D SUPPLEMENTAL NEEDS FUND

The bill eliminates the Medicare Part D Supplemental Needs Fund,

funding for which was eliminated in January 2010. The fund paid for ConnPACE recipients to get drugs that were not on their Part D plan's formulary.

The bill makes related technical, conforming changes.

EFFECTIVE DATE: July 1, 2011

§ 143 — MEDICAID THERAPY MANAGEMENT SERVICES

The bill requires the DSS commissioner to contract with a pharmacy organization to provide Medicaid therapy management services. The organization can include a pharmacy school. The services can include, at a minimum, (1) a review of the medical and prescription history of Medicaid recipients and (2) the development of patient medication action plans to reduce adverse medical interaction and related health problems.

EFFECTIVE DATE: July 1, 2011

§ 144 — LEGISLATIVE OVERSIGHT OF MEDICAID STATE PLAN AMENDMENTS

By law, the DSS commissioner must notify the Human Services and Appropriations committees when his agency intends to request a waiver of any assistance program unless the waiver pertains to routine operational issues. The bill requires that the actual waiver document, instead of just notice, be provided. (In practice, DSS already submits the actual waiver document.) The law establishes a process for the legislature to review these waiver requests (see BACKGROUND).

Under the bill, the DSS commissioner must also follow this process when he is seeking a state plan amendment for any change in program requirements that would have otherwise required a waiver but for the passage of the federal Affordable Care Act. But it sets up a slightly different time frame for public hearings.

Currently, when the Human Services and Appropriations committee chairpersons receive notice that DSS is seeking a federal

waiver for anything other than routine operational issues, within 30 days of receiving the waiver, they must notify the DSS commissioner that they intend to hold a public hearing on it and provide the hearing date, which must be within 60 days of receiving the waiver. Under the bill, if the chairpersons receive a proposed state plan amendment, they must notify the commissioner if they intend to hold a hearing and if so, the date that it will be held, which cannot be more than 60 days after they receive the amendment.

EFFECTIVE DATE: July 1, 2011

§§ 145 & 146 — DELAY IN ESTABLISHING DEPARTMENT ON AGING

The bill postpones the reestablishment of the state Department on Aging by two years, from July 1, 2011 to July 1, 2013. Connecticut disbanded its Department on Aging in 1993 and merged most of its functions and personnel into DSS as the Division of Elderly Services.

EFFECTIVE DATE: January 1, 2011, except a conforming change is effective September 1, 2013.

§§ 147 & 148 — BIRTH-TO-THREE SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDERS

The bill (1) makes changes to the coverage requirements for health insurance policies that provide coverage for medically necessary early intervention (birth-to-three) provided as part of an individualized family service plan and (2) prohibits these policies from imposing co-insurance, copayments, deductibles, or other out-of-pocket expenses for these services, unless they are high-deductible policies designed to be compatible with federally qualified health savings accounts.

It also increases the annual maximum benefit that group health insurers must provide for children with autism spectrum disorders who receive birth-to-three services.

Coverage Requirements

By law, group health insurance policies must cover medically necessary birth-to-three services provided as part of an individualized family service plan. This coverage must include an annual maximum policy benefit of $6,400 per child, with an aggregate benefit of $19,200 per child over the three-year period. The bill expands these coverage amounts for children with autism spectrum disorders to $50,000 per child per year and $150,000 per child over the three-year period.

Current law also requires group health insurance policies to cover the diagnosis and treatment of autism spectrum disorders. Policies can limit the coverage for behavioral therapy to an annual benefit of $50,000 for a child under age nine. But, they must provide unlimited visits to autism services providers if the services are medically necessary (for services such as occupational, physical, and speech therapies). The bill specifies that coverage provided through a birth-to-three individualized service plan must (1) be credited toward these coverage amounts and (2) does not increase these coverage amounts.

Bill Applicability

The bill applies to individual and group health insurance policies delivered, issued, or renewed in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan. Due to the federal Employee Retirement and Income Security Act (ERISA), state health insurance mandates do not apply to self-insured plans.

EFFECTIVE DATE: January 1, 2012

§ 149 — CHRONIC GAMBLERS TREATMENT REHABILITATION ACCOUNT

Beginning in FY 12, the bill increases from $1.5 million to $1.9 million, the amount of lottery revenue that the Connecticut Lottery Corporation must annually transfer to the chronic gamblers treatment rehabilitation account (PA 09-3, June Special Session required the transfer of $1.9 million in FYs 10 and 11).

This account partially funds the Department of Mental Health and Addiction Services' compulsive gambling treatment program. The balance of the funding comes from a fee imposed on dog racing, jai alai, and teletheater licenses. The program provides prevention, treatment, and rehabilitation services for chronic gamblers.

EFFECTIVE DATE: July 1, 2011

§§ 150 & 151 — ANTI-EPILEPTIC PRESCRIPTION DRUGS

The bill prohibits retail pharmacists from filling a prescription to treat epilepsy or prevent seizures using a different manufacturer or distributor of the prescribed drug without (1) prior notice to the patient and prescribing practitioner and (2) the prescriber's written consent. It applies to new and renewal prescriptions that contain an International Classification of Diseases statistical code indicating the drug is used to treat epilepsy or prevent seizures.

The law already permits a prescriber to tell a pharmacist not to substitute a generic name drug for any brand name one.

EFFECTIVE DATE: October 1, 2011

Banning Manufacturer Substitutions For Anti-Epileptic Drugs

The ban applies to community pharmacies, hospital pharmacies that serve employees and outpatients, and mail order pharmacies licensed to distribute drugs in Connecticut. It does not apply to pharmacies (1) in long-term care facilities, such as nursing homes, chronic disease hospitals, and intermediate care facilities for people with mental retardation; (2) serving hospital in-patients; and (3) in other institutions.

The bill requires the pharmacist to notify the prescriber by email or fax to obtain consent. If the prescriber does not consent, the pharmacist must fill the prescription without substitution or return it to the patient or his or her representative for filling at another pharmacy.

If, after making reasonable efforts, a pharmacist cannot contact the

prescriber, he or she may refill a prescription with a 72-hour supply if, in his or her professional judgment, failure to do so might interrupt the patient's therapeutic regimen or cause the patient to suffer. When dispensing the refill, the pharmacist must tell the patient or the patient's representative that the prescriber did not authorize it and inform the prescriber that he or she must authorize future refills. The pharmacist may refill a prescription this way just once.

Drug Substitution

Under existing law, which the bill does not change, a prescriber may tell a pharmacist not to substitute a generic name for any brand name drug. The prescriber must do this by writing "Brand Medically Necessary" on the prescription form or, if the prescriber calls in the prescription or electronically transmits it in a way that does not reproduce his or her handwriting, by stating so on the communication. For Medicaid and ConnPACE clients, the prescriber must (1) specify why the name brand and dosage are medically necessary and (2) send the "brand medically necessary" certification to the pharmacist in writing within 10 days if it was not on the prescription form. This law applies to all pharmacies.

§ 152 — CREMATION CERTIFICATE

By law, cremation certificates are required for the cremation of a body for which a death certificate has been issued. The chief medical examiner, deputy chief medical examiner, associate medical examiner, or an authorized assistant medical examiner must complete the cremation certificate, stating that such person has inquired into the cause and manner of death and believes that no further examination or judicial inquiry is needed. The bill adds an authorized designee to those who can complete the certificate.

EFFECTIVE DATE: July 1, 2011

§§ 153-159 — FALSE CLAIMS ACT

In 2009 the state enacted the Connecticut False Claim Act (CFCA)

applicable to the medical assistance programs that DSS administers (Medicaid, State-Administered General Assistance (SAGA), HUSKY B, and Charter Oak). A false claims act generally allows an individual to bring a civil action in the name of the state to recover fraudulently handled state property or funds. The attorney general may, but need not, join the suit. If successful, the individual is awarded a percentage of the recovery.

The bill broadens the circumstances under which a person is liable for submitting false or materially misleading information in order to obtain or keep funds owed to a state medical assistance provider. It also permits more individuals to file CFCA suits and increases penalties.

Violations

With respect to goods and provided through all DSS medical assistance programs, the bill prohibits anyone from:

1. knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval (current law covers only claims submitted to state officers or employees);

2. knowingly making, using, or causing to be made or used, a false record or statement material to (rather than to secure payment or approval of), a false or fraudulent claim;

3. conspiring to violate the CFCA (rather than to defraud the state by securing the allowance or payment of a false or fraudulent claim);

4. knowingly making, using, or causing to be made or used, a false record or statement material to (rather than to conceal avoid, or decrease) an obligation to pay or transmit money or property to the state;

5. knowingly buying, or receiving as a pledge of an obligation or debt, public property from a state employee or officer who may not legally sell or pledge the property; and

6. knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state.

The bill broadens the definition of "claim" by including demands for property, regardless of whether it belongs to the state (current law is silent on who holds title to the property or money). Under the bill, the demand must be submitted to (1) a state officer, employee, or agent or (2) a contractor, grantee, or other recipient, if the money demanded is to be spent or used on the state's behalf or to advance a state program or interest. The bill also specifies that the prohibitions apply to property that was improperly taken in the past.

It establishes new definitions of "material" and "obligation". Under the bill, something is material if it has a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property. An obligation is an established duty, whether fixed or not, arising from (1) an express or implied contractual, grantor-grantee, or licensor-licensee relationship, (2) a fee-based or similar relationship, (3) statute or regulation, or (4) the retention of an overpayment.

The bill retains as prohibitions:

1. having possession, custody, or control of property or money used, or to be used, by the state relative to these programs, and, with intent to defraud the state or willfully conceal the property, delivering or causing to be delivered less property than the amount for which the person receives a receipt or certificate;

2. being authorized to make or deliver a document certifying receipt of property used, or to be used, by the state relative to these programs and, with intent to defraud the state, making or delivering the document without completely knowing that the information on it is true; and

3. knowingly buying or receiving as a pledge of an obligation or debt public property from a state officer, or employee who may

not lawfully seal or pledge the property.

It permits a request or demand for money or property that the state has paid as compensation to a state employee or as an income subsidy with no restrictions on the individual's use.

Litigation

The bill eliminates a restriction on who can intervene or file a related action based on facts underlying a federal False Claim Act violation. (The state cannot override federal law.) It retains the limitation in existing state law that only the state attorney general can intervene.

Attorney General's Pleadings Relate Back

The law authorizes the attorney general to intervene in a CFCA action brought by a private party. When this occurs, the bill permits the state to (1) file its own complaint, (2) amend the plaintiff's complaint to clarify or add detail to claims in which the attorney general is intervening or (3) add any additional claim under which the state contends it is entitled to relief. If the additional pleadings are based on the same conduct, transactions, or occurrences as in the original complaint, under the bill, the attorney general's claims relate back to the date the original complaint was filed (i.e., the statute of limitations for the state's claims stops running on the date the original complaint was filed).

Penalties

The bill increases the penalties for any of the above violations from: between $5,000 and $10,000 to between $5,500 and $11,000, or as adjusted from time to time by federal law (28 USC § 2461). Other civil penalties are unchanged. If more than one person commits a violation, the bill retains the provision making any, some, or all wrongdoers jointly liable for the entire penalty (jointly liable).

Recovery

The bill allows a person, other than an "original source" to receive up to 10% of the recovery when he or she brings a CFCA suit based on information that was already publicly disclosed in criminal, civil, or administrative hearings or legislative proceedings; by the auditors of public accounts or state or quasi-state agencies; or in the media. Currently, the person bringing the lawsuit under this provision must be an original source.

The bill also narrows the definition of original source. Currently an original source is an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the state before bringing the action. Under the bill, an original source must have (1) informed the state before the information was publicly disclosed, (2) knowledge that is independent of and materially adds to the disclosed allegations, and (3) provided the information to the state before filing suit.

The bill repeals a related provision that denies courts jurisdiction when the person bringing such an action is not the attorney general or an original source, but requires the court to dismiss such an action unless the state opposes dismissal or the plaintiff is either the attorney general or an original source.

The bill also allows a person to file a claim regardless of whether he knew or had reason to know that the attorney general or another state law enforcement official knew of the allegations or transactions prior to such person filing the action.

Broader Whistleblower Protections

The law currently protects employees from adverse job actions when they lawfully participate in a CFCA investigation or action. The bill also protects contractors or agents acting in the same manner. And it extends the permissive actions that trigger the anti-retaliation provisions to those undertaken by employees, contractors, or agents to stop a violation. The bill establishes a three year statute of limitations for bringing a suit alleging adverse job actions. Currently, such claims are not expressly subject to a statute of limitations.

EFFECTIVE DATE: Upon passage

§ 160 — POLICIES AND PROCEDURES FOR HOSPITAL AND ICF-MR USER FEES

Under PA 11-6, the DSS commissioner is permitted to implement policies and procedures necessary to administer the FYs 12-13 biennial budget. This bill limits that authority only to the budget act's provisions regarding the user nursing home, ICF-MR, and hospital user fees.

Policies, Procedures, and Regulations

The bill authorizes the DSS commissioner to implement policies and procedures to administer the program while in the process of adopting them in regulation form, so long as he publishes a notice of his intent to adopt regulations in the *Connecticut Law Journal* within 20 days of implementing the policies and procedures. The policies and procedures are valid for three years following the publication date unless the legislature calls for something otherwise.

Notwithstanding a statute that requires proposed regulations to be submitted within 180 days, the bill requires policies and procedures concerning this program to be submitted in proposed regulation form to the legislative Regulation Review Committee no later than three years after the *Law Journal* notice is published. If the commissioner is unable to submit the proposed regulations by that deadline, he must submit a written notice to the Appropriations, Human Services, and Program Review committees at least 35 days before the proposed regulations are due.

Under the bill, the notice must indicate (1) why DSS cannot meet the deadline and (2) the date by which the department will submit its proposed regulations. The Regulation Review Committee can require the commissioner to appear before the committee at a time it sets to further explain his reasons and to respond to the committee's policy questions. The committee may ask the Human Services Committee to review (1) the DSS policies, (2) its reasons for not submitting proposed

regulations on time, and (3) the date on which it intends to submit them. The Human Services Committee may review this information, schedule a hearing about it, and make a recommendation to the Regulation Review Committee.

EFFECTIVE DATE: July 1, 2011

§§ 161 & 162 — DSS TO ANNUALLY CHANGE THE USER FEES

Current law requires the DSS commissioner to biennially determine the amount of the nursing home and ICF-MR resident user fee. The bill gives him the option to do this annually instead.

The bill also authorizes the commissioner to adjust the user fee as necessary to prevent the state from exceeding the maximum amount allowed under federal law.

EFFECTIVE DATE: July 1, 2011

§ 163 — CHILDHOOD IMMUNIZATION TASK FORCE

Purpose

The bill establishes a childhood immunization task force, which is required to:

1. Develop a plan to:

    a. maintain access to high-quality immunizations for children in the state,

    b. determine how to respond to recommendations by the National Centers for Disease Control for new childhood immunizations not currently provided by the state immunization program administered by the Department of Public Health (DPH).

    c. implement a program permitting health care providers who administer vaccines to children under the federal Vaccines for Children program to select, and DPH to provide,

vaccines licensed by the federal Food and Drug Administration, and

d. determine how best to cover the cost of immunizations for children in the state, and

2. consider whether the state should continue universal immunization for children in the state.

The task force is required to submit a report on its findings and recommendations, including recommendations for legislation, to the Public Health, Human Services, Appropriations, and Insurance and Real Estate committees no later than February 1, 2012. The task force is required to terminate on the date that it submits its report or February 1, 2012, whichever is later.

Membership

Members of the task force are as follows:

1. two representatives (one each appointed by the House speaker and the Senate president pro tempore of the following entities:

   a. the pharmaceutical industry,

   b. the insurance industry, and

   c. the American Academy of Pediatrics.

2. the chairpersons and ranking members of the following committees of the General Assembly:

   a. Public Health,

   b. Human Services,

   c. Appropriations, and

   d. Insurance and Real Estate.

3. The commissioner or the commissioner's designee, of the

following agencies:

a. DPH,

b. the Department of Insurance, and

c. the Department of Social Services.

4. the secretary of the Office of Policy and Management, or the secretary's designee; and

5. an employee of DPH, appointed by the commissioner responsible for immunizations.

Administration

All appointments to the task force are required to be made not later than thirty days after the effective date of this section. Any vacancy of an appointed membership shall be filled by the appointing authority.

The House speaker and the Senate president pro tempore must select the chairpersons of the task force from among the task force members. Such chairpersons must schedule the first meeting of the task force, which must be held not later than 60 days after passage of the bill.

The administrative staff of Public Health Committee and the staff of the Office of Legislative Research shall serve as administrative staff of the task force.

EFFECTIVE DATE: Upon passage

BACKGROUND

Childhood Vaccines

By law, the Public Health commissioner determines the standard of care for childhood immunizations in Connecticut based on the recommended schedules of the: (1) National Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization

Practices, (2) American Academy of Pediatrics, and (3) American Academy of Family Physicians. Currently, DPH operates a federal "Vaccine for Children" program and its own immunization program funded by an assessment on health insurers.

Federal Vaccine for Children Program (VFC)

The VFC is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. VFC was created by the Omnibus Budget Reconciliation Act of 1993 as a new entitlement program required as part of each state's Medicaid plan. VFC pays for any brand of vaccine that the CDC has recommended.

§ 164 — RESTRICTING GROUP HOME RESIDENTS UNDER AGE SIX

The bill generally prohibits the DCF commissioner from placing any child under age 6, or any sibling group including a child under that age, in a child caring facility (group home). The bill's exceptions are if the:

1. home is designed for children and their parents or
2. child's health needs are so severe that that they can only be met in a group home.

When a child or a sibling group containing such a child is placed in a group home, the DCF commissioner must certify to the court that specific attempts were made to secure a family-based (foster care) placement. The certification must be filed in court within 96 hours of the placement. If the child or sibling group remains in the group home for more than 30 days, the commissioner must petition the court for an emergency placement review hearing. The hearing must be held more than 45 days after the placement and its purpose is to review the commissioner's efforts to find a family-based placement and to determine whether the child's health needs warrant continued placement in the group home.

EFFECTIVE DATE: July 1, 2012

§ 165 — PILOT PROGRAM FOR TEMPORARY FAMILY ASSISTANCE RECIPIENTS

The bill requires the DSS and labor commissioners, within available appropriations, to implement a pilot program, for up to 100 people who (1) receive TFA benefits and (2) participate in the Jobs First Employment Services (JFES) program.

Program Services

The bill requires the pilot program to provide to participants:

1. intensive case management services to identify their employment goals and support services (e.g., child care) training, education, and work experience needs;

2. help in accessing the support services, training, education, and work experience; and

3. funding to facilitate their participation in necessary adult basic education, skills training, post-secondary education, or subsidized employment.

Many of these services and supports are already available to JFES clients.

Report

The bill requires both commissioners to submit a joint report to the Human Services and Appropriations committees by October 1, 2012. The report must include:

1. the number of participants;

2. the education, training, and work experience activities of participants;

3. the support services that the case manager determines are

needed and those that program participants actually receive;

4. educational degrees and certificates participants obtain; and

5. a description of jobs that participants get as a result of the pilot.

TFA Extensions for Pilot Participants

The bill requires the DSS commissioner to extend TFA program benefits beyond 21 months to pilot participants who have made a good faith effort to comply with the pilot requirements, have not received more than 60 months of TFA benefits, and who have not been granted more than two extensions.

Federal and state laws generally prohibit states from providing assistance to a family for more than 60 months. Currently, DSS grants up to two extensions to families that have made a good faith effort to comply with the Jobs First requirements but have family income less than the TFA benefit. Extensions can also be granted in other circumstances, including domestic violence. DSS can grant subsequent extensions in certain circumstances.

The bill does not (1) specify how long the pilot runs, (2) specify how participants are selected, or (3) define what is expected of participants for them to be considered in compliance. It also does not specify whether these families are counted in the state's Temporary Assistance for Needy Families (TANF) work participation rate.

EFFECTIVE DATE: July 1, 2011

§ 166 — INCREASE IN DSS PAYMENTS TO ADULT DAY CARE CENTERS

The bill requires the DSS commissioner, beginning July 1, 2011, to increase by $4 per person, per day, the fees that DSS pays for adult day care services. The current rates are (1) $66.22 for full day with approved medical model providers; $62.18 for full day with non-medical model providers; and, $40.54 for half day. (It is unclear whether the fee change would apply proportionately, thereby

requiring a $2 increase for the half-day services.)

The law, unchanged by the bill, continues to allow DSS to annually increase these fees, which are set in a schedule, based on increases in service costs. The state's rate for these services cannot exceed that charged to the public.

EFFECTIVE DATE: July 1, 2011

§§ 167-172 — COUNCIL OVERSEEING DSS MEDICAL ASSISTANCE PROGRAMS

Council Duties

By law, a council oversees the HUSKY A program. (In practice, the council has overseen HUSKY B and Charter Oak, too.) The bill renames the Council on Medicaid Care Management Oversight as the Council on Medical Assistance Program Oversight, to reflect its larger role, and in light of DSS converting its delivery model from full-risk MCOs to an administrative services organization (ASO). The bill continues to charge the council with advising the DSS commissioner on implementing HUSKY A, but expands this to include all of Medicaid, including low-income adults and aged, blind, and disabled adults; people dually eligible for Medicaid and Medicare; and people with preexisting medical conditions.

Under current law, the council must make recommendations on a wide range of issues. The bill expands those requirements and additionally requires the council to monitor them.

In addition to its current duties of monitoring planning and implementation of initiatives, the bill requires the council to monitor implementation of outcome measures and the issuance of the request for proposals for the ASO, which DSS issued in April 2011.

The bill requires the council to monitor, as well as make recommendations, concerning a number of areas, one of which is the sufficiency of provider networks. The bill instead requires review of accessible adult and child primary care providers, specialty providers,

and hospitals in Medicaid provider networks.

Currently, the council must look at the sufficiency of capitated rates, provider payments, financing, and staff resources to guarantee timely access to services. Under the bill, the council must monitor and make recommendations regarding provider rates to maintain the Medicaid network of providers and service access. And it must do the same for funding and agency personnel resources to guarantee access to services and effective management of the Medicaid program.

The bill also specifies that when the council is monitoring and recommending changes concerning care management models, this includes medical homes and health home models. Likewise, when reviewing quality assurance, it must look at outcome measures and continuous quality improvement initiatives that may include provider quality performance incentives and performance targets for ASOs.

Currently, the council looks at how coverage is coordinated under HUSKY and other health care programs. The bill requires coordination of coverage without specifying program names, and requires the council to look at continuity among Medicaid programs and integration of care, including, (1) behavioral health, (2) dental, and (3) pharmacy care that DSS provides. (DSS has carved these three areas out of HUSKY managed care over the last several years.)

The chairperson must ensure that a sufficient number of members participate in the review of any contracts DSS enters into with an ASO.

Council Membership

The bill changes the composition of the council as of July 1, 2011 as follows:

Appointing Authority	*Current Law*	*Bill*
House speaker	One legislator, two insurance industry representative*, one advocate for DCF foster families	One legislator; one community provider of adult Medicaid; one Medicaid aged, blind, or disabled recipient or his or her advocate; one representative of federally qualified health center (FQHC)
Senate president pro tempore	One legislator, representative from each MCO,* representative of primary care case management (PCCM) provider, advocate for DCF foster families	One legislator, one home health care industry representative, one primary care medical home provider, one advocate for foster families
House majority leader	Advocate for people with substance abuse disorders, Medicaid recipient	One advocate for people with substance abuse disabilities, one Medicaid dental provider
Senate majority leader	Advocate for person receiving Medicaid	One representative of school-based health centers, one HUSKY recipient
House minority leader	Advocate for people with psychiatric disabilities, Medicaid recipient	One advocate for people with disabilities, one dually eligible person
Senate minority leader	Advocate for person receiving Medicaid	One Medicaid LIA recipient or his or her advocate, one hospital representative
Ex-officio, nonvoting members	Chairs and ranking members of Human Services, Public Health, Appropriations	Same
	Executive director of the Commission on Aging, or her designee	Same
	Executive director of the Commission on Children, or her designee	Same
	Two representatives each from DSS, DPH, DMHAS, DCF, OPM, appointed by agency heads	Commissioners of DSS, DCF, DPH, DDS, DMHAS, OPM secretary
	Representative from Comptroller's office that he appoints	Comptroller or his designee,
		Representative from ASO contracting with DSS for Medicaid administration,
TOTAL	**41* (39 actual)**	**38 (30 are voting members)**

* There are only three insurance representatives, not five. Currently, The House speaker appoints two MCO representatives and the Senate president pro tempore appoints one.

Reporting

Currently, DSS must provide monthly reports to the council on the plans and implementation of HUSKY. The bill instead requires him to report on matters that the council monitors and on which it makes

recommendations, including policy changes and proposed regulations that affect Medicaid health services. The commissioner must also provide the council with quarterly reports for each covered Medicaid population. These latter reports must include a breakdown of amounts spent for each population.

The bill also requires the council to report to the General Assembly biennially instead of quarterly.

EFFECTIVE DATE: July 1, 2011

§ 173 — AIDS SERVICES FOR RAPE VICTIMS

The bill directs the DPH commissioner to establish and contract for the administration of a program using AIDS Services funding to provide financial assistance to rape victims. The funds are for physician-prescribed drugs for nonoccupational post-exposure prophylaxis for HIV consistent with recommendations of the National Centers for Disease Control and Prevention and the Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault.

Under the bill, the commissioner must give priority for benefits to uninsured or underinsured victims for whom the program is the payor of last resort. He must issue a request for proposal totaling $25,000 yearly to which a qualified organization may apply to administer the program.

EFFECTIVE DATE: July 1, 2011

§ 178 — REPEALERS

The bill repeals provisions that:

1. require the governor to appoint a BESB executive director (§ 10-294),

2. require the DMHAS commissioner to operate a behavioral health managed care program for SAGA recipients (§§ 17a-453a,

453b, 17b-200);

3. establish a SAGA medical assistance program (§ 17b-192);

4. require Office of Health Care Access to establish state hospital rates during a waiver period (§ 17b-240);

5. permit DSS to enter into a contract with a consortium of federally qualified health centers to run SAGA medical assistance program (§ 17b-256d);

6. allow the spouse of someone in a nursing home who is still at home to keep the maximum community spouse protected amount instead of one half of the assets, up to the maximum (§ 17b-261k);

7. require DSS to develop and implement a two-year pilot program for 19- to 21-year-olds with one or more mental disorders (§ 17b-263b);

8. establish the Medicare Part D Supplemental Needs Fund (§ 17b-265e);

9. authorize a Long-Term Care Reinvestment Account that holds enhanced federal Medicaid matching funds the state receives from the Money Follows the Person Demonstration program (§ 17b-371);

10. require DSS to establish an adult foster care program (§ 17b-424);

11. require DSS to maintain a Bureau of Rehabilitation Services (§ 17b-651),

12. transferred BRS into DSS when agencies were reorganized in 1993 (§ 17b-652), and

13. limit pharmacists who can participate in ConnPACE to those that accept Medicare Part D drug discount cards (§ 17b-492a);

14. require hospitals that engage in inefficient or inappropriate provision of uncompensated care to submit cost reports (§ 19a-662);

15. establish a toll-free phone line for use by BRS and its clients (§ 17b-664).

16. require the OPM secretary to inform OHCA of the maximum DSH payments (§ 19a-669);

17. require DSS to promptly apply to the federal Medicaid agency for any necessary approvals, if needed, to carry out the DSH program (§19a-670a);

18. establish the formula for calculating DSH payments (§ 19a-671);

19. authorize DSS to adjust any DSH overpayments by reducing Medicaid payments to hospitals (§ 19a-671a);

20. provide that DSH appropriations must be used to make DSH payments to hospitals (§ 19a-672);

21. permit the DSS commissioner to make DSH payments to short-term general hospitals that change ownership in the middle of a hospital fiscal year (§ 19a-672a); and

22. establish a DSH reconciliation account in the General Fund (§ 19a-683).

BACKGROUND

HUSKY B Premiums and Federal Stimulus and Health Care Reform Legislation

The federal government recently informed DSS that the HUSKY B premium increases enacted in 2010 were not allowed by either the American Recovery and Reinvestment Act or the federal Affordable Care Act's maintenance of effort (MOE) requirements. DSS is in the process of refunding the increases to families. But the state is permitted to increase premiums prospectively if the increase is based on an

increase in the consumer price index (CPI)-Medical Services and the state receives federal approval to do so.

Legislative Oversight of DSS Waiver Requests

When DSS seeks a federal waiver for anything but routine operational issues, it must seek legislative approval, which includes a public hearing.

Once the hearing is concluded, the Human Services and Appropriations committees must advise the commissioner of their approval, denial, or modifications, if any, of the proposed amendment. If the committees advise the commissioner that they are denying the amendment, the commissioner may not submit it to the federal government.

If the committees do not agree, the chairpersons must appoint a conference committee composed of three members from each committee. At least one member from each committee must be from the minority party. The conference committee must report to both standing committees, which must vote to accept or reject the report. The report may not be amended.

If either standing committee rejects the conference report, that committee must notify the commissioner and the proposed waiver is deemed approved. If the committees accept the report, the Appropriations Committee must advise the commissioner of their approval, denial, or modifications of the waiver. If the committees do not advise the commissioner within 60 days, the waiver is deemed approved.

Any proposed waiver submitted to the federal government must be in accordance with the approval or modifications of the committees.

Before submitting a waiver to the committees, the DSS commissioner must publish notice in the *Connecticut Law Journal* that he intends to submit the waiver, including a summary of the waiver's provisions and the manner in which individuals may submit

comments. The commissioner must allow 15 days for written comments before submitting the waiver to the committees and must include these comments with his submission.

The commissioner, when submitting the proposed waiver to the federal government, must submit (1) written comments received and (2) a complete transcript of the public hearing, including any additional written comments submitted at the hearing. The bill requires the committees to send any such materials to the commissioner for this purpose.

Jobs First

The Jobs First program is the state's welfare-to-work program under which the state provides cash assistance (TFA) and employment services to enable low-income families to become self-sufficient within the program's 21-month time limit. Able-bodied adults in families receiving TFA work with a case manager to develop an employment plan that includes activities to ensure that they find work and can support their families by the end of the 21-month period. Federal and state laws prescribe the types of work-related activities in which the adult may participate and have those activities count towards the federal TANF work participation rate.